DUCKWORTH) was added as a cosponsor of S. 3104, a bill to make technical corrections relating to parental leave for Federal employees.

S.J. RES. 6

At the request of Mr. CARDIN, the names of the Senator from California (Ms. HARRIS), the Senator from Colorado (Mr. BENNET), the Senator from Connecticut (Mr. MURPHY), the Senator from Hawaii (Ms. HIRONO), the Senator from Michigan (Mr. PETERS), the Senator from Minnesota (Ms. KLOBUCHAR), the Senator from Minnesota (Ms. SMITH), the Senator from New Hampshire (Ms. HASSAN), the Senator from New Jersey (Mr. BOOKER), the Senator from New Jersey (Mr. MENENDEZ), the Senator from Nevada (Ms. CORTEZ MASTO), the Senator from Nevada (Ms. ROSEN), the Senator from Rhode Island (Mr. WHITEHOUSE) and the Senator from Vermont (Mr. SANDERS) were added as cosponsors of S.J. Res. 6, a joint resolution removing the deadline for the ratification of the equal rights amendment.

S. RES. 73

At the request of Mr. RUBIO, the name of the Senator from New York (Mrs. GILLIBRAND) was added as a cosponsor of S. Res. 73, a resolution calling on the Kingdom of Saudi Arabia to immediately release Saudi Women's Rights activists and respect the fundamental rights of all Saudi citizens.

S. RES. 452

At the request of Mr. COONS, the name of the Senator from Massachusetts (Ms. WARREN) was added as a cosponsor of S. Res. 452, a resolution commemorating and supporting the goals of World AIDS Day.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Ms. COLLINS (for herself, Mr. JONES, Ms. MCSALLY, and Mr. MENENDEZ):

S. 3116. A bill to enable States to better provide access to whole genome sequencing clinical services for certain undiagnosed children under the Medicaid program, and for other purposes; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today to introduce the Ending the Diagnostic Odyssey Act. This legislation gives States the option of providing whole genome sequencing WSG clinical services through Medicaid for children with a disease that is suspected to have a genetic cause, at an enhanced Federal matching rate for 3 years. I am pleased to be joined by Senators JONES, MCSALLY, and MENENDEZ.

Children with rare diseases will spend on average 5 to 7 years on diagnostic odyssey, and 30 percent of those children will not survive beyond the age of 5 years old. The average patient sees seven different physicians in that time. The wait to find a cause—nevermind a cure—can be excruciating. Parents try to project a calm and reassuring presence for their child while facing a whirlwind of doctor appointments, hospital visits, and unanswered questions.

Undeniably, we are making progress in both accelerating research funding for rare diseases as well as in the development of diagnostics. In 2014, the National Institutes of Health, NIH launched a program called the Undiagnosed Disease Network UDN. In its first 20 months, the UDN accepted 601 participants undiagnosed by traditional medical practices. Of those who completed their UDN evaluation during this time, 35 percent were given a diagnosis. Many of these diagnoses were rare genetic diseases, including 31 previously unknown syndromes.

In May, the Director of the National Institutes of Health, Dr. Francis Collins, wrote a blog post on how whole genome sequencing—combined with artificial intelligence, AI—can now be used to diagnose genetic diseases in seriously ill babies in fewer than 24 hours. Dr. Collins writes: ''I would submit that there is no other technology in the history of planet Earth that has experienced this degree of progress in speed and affordability.''

For parents of children with an undiagnosed illness, answers cannot come soon enough. There are approximately 7,000 rare diseases known today. Approximately 80 percent of rare diseases are genetic, and about one-half of all rare diseases affect children. For example, Alström syndrome is an extremely rare and complex genetic disorder. Approximately 1,200 affected individuals have been identified worldwide, which makes a obtaining a correct diagnosis challenging. Characteristics of Alström syndrome include vision disturbances, sensorineural hearing impairment, cardiomyopathy, obesity, kidney dysfunction, and diabetes.

Robin Marshall, executive director of the Alström Syndrome International, located in Mount Desert Islanas, ME, has said that ''whole Genome Sequencing has changed the lives of those we represent by enabling earlier and more accurate diagnosis, fostering more timely and appropriate medical care, and unlocking a host of social services to combat the educational and psychosocial complications that our children confront.''

By giving States an incentive to provide whole genome sequencing for eligible children through Medicaid my legislation will ensure that more children and their families can obtain the right diagnosis and treatment the start. The Ending the Diagnostic Odyssey Act has the support of more than 100 patient advocacy organizations, including Alström Syndrome International, the Genetic Alliance, the Personalized Medicine Coalition, and many others. I urge my colleagues to support this legislation.

By Mr. MANCHIN (for himself and Mrs. CAPITO):

S. 3147. A bill to require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes; considered and passed.

S. 3147

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Safety and Security for Veterans Act of 2019''.

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REPORTS ON PATIENT SAFETY AND QUALITY OF CARE.

(a) REPORT ON PATIENT SAFETY AND QUALITY OF CARE.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report regarding the policies and procedures of the Department relating to patient safety and quality of care and the steps that the Department has taken to make improvements in patient safety and quality of care at medical centers of the Department.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A description of the policies and procedures of the Department and improvements made by the Department with respect to the following:

(i) How often the Department reviews or inspects patient safety at medical centers of the Department.

(ii) What triggers the aggregated review process at medical centers of the Department.

(iii) What controls the Department has in place for controlled and other high-risk substances, including the following:

(I) Access to such substances by staff.

(II) What medications are dispensed via automation.

(III) What systems are in place to ensure proper matching of the correct medication to the correct patient.

(IV) Controls of items such as medication carts and pill bottles and vials.

(V) Monitoring of the dispensing of medication within medical centers of the Department, including monitoring of unauthorized dispensing.

(iv) How the Department monitors contact between patients and employees of the Department, including how employees are monitored and tracked at medical centers of the Department when entering and exiting the room of a patient.

(v) How comprehensively the Department uses video monitoring systems in medical centers of the Department to enhance patient safety, security, and quality of care.

(vi) How the Department tracks and reports deaths at medical centers of the Department at the local level, Veterans Integrated Service Network level, and national level.

(vii) The procedures of the Department to alert local, regional, and Department-wide leadership when there is a statistically abnormal number of deaths at a medical center of the Department, including—

(I) the manner and frequency in which such alerts are made; and

(II) what is included in such an alert, such as the nature of death and where within the medical center the death occurred.

(viii) The use of root cause analyses with respect to patient deaths in medical centers of the Department, including—

(I) what threshold triggers a root cause analysis for a patient death;

(II) who conducts the root cause analysis; and

(III) how root cause analyses determine whether a patient death is suspicious or not.

(ix) What triggers a patient safety alert, including how many suspicious deaths cause a patient safety alert to be triggered.

(x) The situations in which an autopsy report is ordered for deaths at hospitals of the Department, including an identification of—

(I) when the medical examiner is called to review a patient death; and

(II) the official or officials that decide such a review is necessary.

(xi) The method for family members of a patient who died at a medical center of the Department to request an investigation into that death.

(xii) The opportunities that exist for family members of a patient who died at a medical center of the Department to request an autopsy for that death.

(xiii) The methods in place for employees of the Department to report suspicious deaths at medical centers of the Department.

(xiv) The steps taken by the Department if an employee of the Department is suspected to be implicated in a suspicious death at a medical center of the Department, including—

(I) actions to remove or suspend that individual from patient care or temporarily reassign that individual and the speed at which that action occurs; and

(II) steps taken to ensure that other medical centers of the Department and other non-Department medical centers are aware of the suspected role of the individual in a suspicious death.

(xv) In the case of the suspicious death of an individual while under care at a medical center of the Department, the methods used by the Department to inform the family members of that individual.

(xvi) The policy of the Department for communicating to the public when a suspicious death occurs at a medical center of the Department.

(B) A description of any additional authorities or resources needed from Congress to implement any of the actions, changes to policy, or other matters included in the report required under paragraph (1)

(b) REPORT ON DEATHS AT LOUIS A. JOHNSON MEDICAL CENTER.—

(1) IN GENERAL.—Not later than 60 days after the date on which the Attorney General indicates that any investigation or trial related to the suspicious deaths of veterans at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, (in this subsection referred to as the ''Facility'') that occurred during 2017 and 2018 has sufficiently concluded, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report describing—

(A) the events that occurred during that period related to those suspicious deaths; and

(B) actions taken at the Facility and throughout the Department of Veterans Affairs to prevent any similar reoccurrence of the issues that contributed to those suspicious deaths.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A timeline of events that occurred at the Facility relating to the suspicious deaths described in paragraph (1) beginning the moment those deaths were first determined to be suspicious, including any notifications to—

(i) leadership of the Facility;

(ii) leadership of the Veterans Integrated Service Network in which the Facility is located;

(iii) leadership at the central office of the Department; and

(iv) the Office of the Inspector General of the Department of Veterans Affairs.

(B) A description of the actions taken by leadership of the Facility, the Veterans Integrated Service Network in which the Facility is located, and the central office of the Department in response to the suspicious deaths, including responses to notifications under subparagraph (A).

(C) A description of the actions, including root cause analyses, autopsies, or other activities that were conducted after each of the suspicious deaths.

(D) A description of the changes made by the Department since the suspicious deaths to procedures to control access within medical centers of the Department to controlled and non-controlled substances to prevent harm to patients.

(E) A description of the changes made by the Department to its nationwide controlled substance and non-controlled substance policies as a result of the suspicious deaths.

(F) A description of the changes planned or made by the Department to its video surveillance at medical centers of the Department to improve patient safety and quality of care in response to the suspicious deaths.

(G) An analysis of the review of sentinel events conducted at the Facility in response to the suspicious deaths and whether that review was conducted consistent with policies and procedures of the Department.

(H) A description of the steps the Department has taken or will take to improve the monitoring of the credentials of employees of the Department to ensure the validity of those credentials, including all employees that interact with patients in the provision of medical care.

(I) A description of the steps the Department has taken or will take to monitor and mitigate the behavior of employee bad actors, including those who attempt to conceal their mistreatment of veteran patients.

(J) A description of the steps the Department has taken or will take to enhance or create new monitoring systems that—

(i) automatically collect and analyze data from medical centers of the Department and monitor for warnings signs or unusual health patterns that may indicate a health safety or quality problem at a particular medical center; and

(ii) automatically share those warnings with other medical centers of the Department, relevant Veterans Integrated Service Networks, and officials of the central office of the Department.

(K) A description of the accountability actions that have been taken at the Facility to remove or discipline employees who significantly participated in the actions that contributed to the suspicious deaths.

(L) A description of the system-wide reporting process that the Department will or has implemented to ensure that relevant employees are properly reported, when applicable, to the National Practitioner Data Bank of the Department of Health and Human Services, the applicable State licensing boards, the Drug Enforcement Administration, and other relevant entities.

(M) A description of any additional authorities or resources needed from Congress to implement any of the recommendations or findings included in the report required under paragraph (1).

(N) Such other matters as the Secretary considers necessary.

By Mr. JOHNSON (for himself, Mr. COTTON, Mr. CASSIDY, Mrs. BLACKBURN, Ms. ERNST, Mr. BRAUN, Mr. ALEXANDER, Mr. MCCONNELL, and Mr. LANKFORD):

S. 3148. A bill to amend the Controlled Substances Act to list fentanyl-related substances as schedule I controlled substances; read the first time.

S. 3148

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Stopping Overdoses of Fentanyl Analogues Act''.

SEC. 2. FENTANYL-RELATED SUBSTANCES.

Section 202(c) of the Controlled Substances Act (21 U.S.C. 812) is amended—

(1) by adding at the end of subsection (b) of Schedule I the following:

''(23) Isobutyryl fentanyl.

''(24) Para-Methoxybutyrylfentanyl.

''(25) Valeryl fentanyl.

''(26) Cyclopentyl fentanyl.

''(27) Para-Chloroisobutyryl fentanyl.''; and

(2) by adding at the end of Schedule I the following:

''(e)(1) Unless specifically exempted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of fentanyl-related substances, or which contains their salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation.

''(2) In paragraph (1), the term 'fentanyl-related substances' includes the following:

''(A) Any substance that is structurally related to fentanyl by one or more of the following modifications:

''(i) By replacement of the phenyl portion of the phenethyl group by any monocycle, whether or not further substituted in or on the monocycle.

''(ii) By substitution in or on the phenethyl group with alkyl, alkenyl, alkoxy, hydroxy, halo, haloalkyl, amino or nitro groups.

''(iii) By substitution in or on the piperidine ring with alkyl, alkenyl, alkoxy, ester, ether, hydroxy, halo, haloalkyl, amino or nitro groups.

''(iv) By replacement of the aniline ring with any aromatic monocycle whether or not further substituted in or on the aromatic monocycle.

''(v) By replacement of the N-propionyl group by another acyl group.

''(B) 4′-Methyl acetyl fentanyl.

''(C) Crotonyl fentanyl.

''(D) 2′-Fluoro ortho-fluorofentanyl.

''(E) Ortho-Methyl acetylfentanyl.

''(F) Thiofuranyl fentanyl.

''(G) Ortho-Fluorobutyryl fentanyl.

''(H) Ortho-Fluoroacryl fentanyl.

''(I) Beta-Methyl fentanyl.

''(J) Phenyl fentanyl.

''(K) Para-Methylfentanyl.

''(L) Beta′-Phenyl fentanyl.

''(M) Benzodioxole fentanyl.''.

This act shall take effect one day after the date of enactment.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 458—CALLING FOR THE GLOBAL REPEAL OF BLASPHEMY, HERESY, AND APOSTASY LAWS

Mr. LANKFORD (for himself and Mr. COONS) submitted the following resolution; which was referred to the Committee on Foreign Relations: